U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 09 January 2007

In the Matter of

Mr. H.R.,[1]
through Mrs. H.R.,[2]
Claimant

Case No.: 2005 BLA 5047

v.

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Respondent

Appearances: Mr. H.R.
Pro Se

Ms. Suzanne F. Dunne, Attorney
For the Director

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER –
DENIAL OF BENEFITS

This matter involves a claim filed by Mr. H.R. for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"), as implemented by 20 C.F.R. Parts 718 and 725. Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

[1]Despite 20 C.F.R. § 725.477(b) ("A decision and order shall contain . . . the names of the parties. . . ."), and over my specific objection, Chief Administrative Law Judge John Vittone has directed that I substitute initials for the names of the Claimant and all family members. Any comments or concerns regarding this mandated practice should be directed to Chief Administrative Law Judge John Vittone, 800 K Street, Suite 400N, Washington, D.C. 20001.

[2]Less than a month after the October 25, 2005 hearing, Mr. R. unfortunately passed away. Subsequently, Mrs. R. elected to proceed with her husband's claim for black lung disability benefits. I note that Mr. R's claim does not include a survivor claim by Mrs. R. If Mrs. R. wishes to file a survivor's claim, she must initiate that claim with the District Director.

Procedural Background

First Claim
(DX 1[3])

Mr. R. filed his first claim for federal black lung disability benefits on April 4, 1985. The U.S. Department of Labor ("DOL") denied the claim on October 1, 1985 because Mr. R. did not show that he had pneumoconiosis.

Present Claim

Mr. R. filed his second, present claim on August 29, 2003 (DX 32). On October 16, 2003, the District Director issued an Order to Show Cause as to Why Claim Should Not Be Denied – Not a Miner (DX 16). On November 7, 2003, Mr. R. informed the District Director that he was contacting people who could provide evidence for his claim (DX 17). On May 5, 2004, the District Director denied the claim in a Proposed Decision and Order, because Mr. R. did not show that he was employed as a coal miner, nor that he suffered from pneumoconiosis (DX 19). On July 12, 2004, Mr. R. sent a copy of a letter from his former employer, signed by four other people, as evidence that he worked for a railroad cleaning coal cars (DX 20). On July 26, 2004, the District Director informed Mr. R. that his additional evidence did not alter the earlier finding (DX 21). On August 18, 2004, Mr. R. requested a formal hearing before the Office of Administrative Law Judges (DX 22). The District Director forwarded the case to OALJ on October 1, 2004 (DX 24).

After one continuance, and pursuant to a Notice of Hearing dated August 8, 2005 (ALJ I), I conducted a hearing in Cardondale, Illinois on October 25, 2005, attended by Mr. R., Mrs. R., several members of Mr. R.'s family, and Ms. Dunne.

Evidentiary Discussion

At the hearing, I left the record open for Mr. R. to submit medical records in support of his claim. On November 25, 2005, I received a letter from Mrs. R. informing me that her husband passed away on November 18, 2005. At that time, Mrs. R. sent me a copy of the preliminary autopsy report, the death certificate, one page of medical treatment records from 2003, a copy of an employment verification letter, and two pages of photocopies of a medical dictionary. Mrs. R. also requested that the record be left open for submission of the final autopsy. I granted Mrs. R.'s request in a Notice of Additional Evidence dated December 1, 2005, and left the record open for the Director to provide responsive evidence. On March 7, 2006, Mrs. R. sent the final autopsy report and 2005 medical treatment records to me. On May 8, 2006 the Director submitted a medical report by Dr. Samuel Spagnolo.

I admit the medical treatment records from 2003 and 2005 as CX 1. The death certificate is admitted as CX 2. Under 20 C.F.R. § 725.414(a)(2), a claimant may submit one autopsy report for his case-in-chief. Accordingly, I admit the preliminary and final autopsy reports as a

[3]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

single autopsy report in CX 3. The medical dictionary photocopies are admitted as CX 4. I note, however, that I am bound by the regulatory definitions of "pneumoconiosis" and "anthracosis" at 20 C.F.R. § 718.201. I do not admit Claimant's photocopy of an employment verification letter from Mr. Ken Wilson, signed also by Mr. R. and four other people, as it is duplicative of what is already contained in the record in DX 20.

I admit Dr. Spagnolo's medical evaluation as a medical report for the Director, DX 25.

Accordingly, my decision in this case is based on the hearing testimony and the following documents admitted into evidence: DX 1 to DX 25, CX 1 to CX 4.

ISSUES

1. Coal miner

2. Length of coal mine employment.

3. Whether in filing a subsequent claim on August 29, 2003, Mr. R. demonstrated that a change has occurred in one of the conditions, or elements, of entitlement upon which the denial of his first claim was based in October 1985.

4. If a change in one of the applicable conditions of entitlement is established, whether Mr. R. was entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Preliminary Findings

Born on January 23, 1921, Mr. R. married Mrs. M.R. on June 15, 1957. Mr. R. worked for a railroad company from the late 1950s to the mid-1960s as a coal car cleaner at a coal mine.[4] When the mine closed in August 1966, he became a railroad trackman. Mr. R. stopped working as a trackman in January 1982. Mr. R. smoked cigarettes between 1942 and 1982, at the rate between one to two packs per day. Mr. R. passed away on November 18, 2005. (DX 1 to DX 7, CX 2, TR p.16-20, 23-24)

Issue # 1 – Coal Miner

As highlighted by the District Director's adjudication, a significant issue exists as to whether Mr. R. was a coal miner under the Act.

[4]Mr. R.'s employment history is discussed in more detail below.

Work History

Mr. R.'s employment history consists of essentially two phases. In the beginning of his career, from September 1957 to August 1966, Mr. R worked for a railroad company at a coal mine. His job was to clean coal, coal dust, and rocks out of railroad cars prior to the cars being moved to the tipple to be loaded with coal. Up to two feet of residual coal and a couple of inches of coal dust needed to be removed from the cars before they could be reloaded. Mr. R. used a shovel and a broom for the job, with shovel loads of 25 to 30 pounds. The job was located on mine property, and Mr. R. worked with coal mine employees. He worked 6 days a week, and would return home covered head to toe in black dust. In 1966, the coal mine shut down and Mr. R. began the second phase of his career as a trackman for the railroad company. In this second job, he was exposed to coal dust "at times" as rail cars passed by, looking like a "black storm" (TR, p.16-20, 27, and 39).

Discussion

Since Mr. R.'s work clearly did not involve traditional underground coal mining, I must determine whether his jobs as a coal car cleaner and a trackman nevertheless qualify him as a miner under the Act. During this process, I am guided by following principles set out by the regulations, the Benefit Review Board ("BRB"), and federal appellate courts.

In deciding whether Mr. R.'s work qualifies him as a miner, the starting point is the regulatory definition of miner. According to 20 C.F.R. § 725.202(a), a miner is:

> [A]ny person who . . . worked in or around a coal mine or coal preparation facility in the extraction, preparation, or transportation of coal, and any person who . . . worked in coal mine construction or maintenance in or around a coal mine or coal preparation facility. There shall be a rebuttable presumption that any person working in or around a coal mine or coal preparation facility is a miner.

To apply the regulatory definition of "miner," the BRB applies a three prong test. The initial prong is whether the coal was still in the course of being processed and was not yet a finished product (status). The next factor is whether the worker performed a critical function during the coal production process (function). The last element is whether the work was performed in or around a coal mine or coal preparation facility (situs).

The U.S. Court of Appeals for the Seventh Circuit, which has jurisdiction over this claim, reduced the BRB's test to two points. In general, to qualify as a miner, a claimant only has to meet the function and situs elements. *Mitchell v. Director, OWCP,* 855 F.2d 485 (7th Cir. 1988). Under the function prong, the claimant's work has to be an integral or necessary part of the overall coal extraction and preparation process. *Canonico v. Director, OWCP,* 7 B.L.R. 1-547 (1984). The phrase "coal preparation" is defined by 20 C.F.R. § 725.101(a)(13) as the "breaking, crushing, sizing, cleaning, washing, drying, mixing, storing and loading of . . . coal, and such other work of preparing coal as is usually done by the operator of a coal mine." An individual need not be engaged in the actual extracting or preparing of coal to meet the function test so long

as the work he performed was integral to the coal production process. *Ray v. Williamson Shaft Contracting Co.*, 14 B.L.R. 1-105 (1990) (en banc).

Concerning the situs prong, the regulation at 20 C.F.R. § 725.101(a)(12) defines the term "coal mine" as the following:

> [A]n area of land and all structures, facilities, machinery, tools, equipment, shafts, slopes, tunnels, excavations and other property, real or personal, place upon, under or above the surface of such land by any person, used in, or to be used in, or resulting from, the work of extracting in such area bituminous coal, lignite, or anthracite from its natural deposits in the earth by any means or method, and in the work of preparing the coal so extracted, and includes custom coal preparation facilities.

The focus of the situs inquiry is whether the intended use of the area of land on which the claimant worked was for the extraction or preparation of coal. *McKee v. Director, OWCP,* 2 B.L.R. 1-804 (1980).

Following the function/situs tests, the Seventh Circuit found a railroad worker to be a "miner" when he worked on mine property cleaning out railroad cars before they were reloaded with coal.[5] *Mitchell*, 855 F.2d at 489-90. The railroad worker's job was "related to the preparation of coal for delivery, not to the delivery of a finished product to consumers in the stream of commerce." *Id*. at 490. The job fell under the "loading" category of the "coal preparation" definition above, because "this work necessarily was performed prior to the loading of coal on the cars." *Id*. As a result, the railroad worker "was involved in the preparation of coal for delivery, not in the delivery of the finished product to consumers in the stream of commerce." *Id*.

Mr. R.'s work as a coal car cleaner is very similar to the work performed in *Mitchell*. Mr. R. was employed by the railroad but worked at the coal mine location, just like the *Mitchell* claimant. Both Mr. R. and the *Mitchell* claimant cleaned railroad coal cars to get them ready for new coal. In *Mitchell*, it was known that the railroad company delegated supervisory authority for its employee to the coal mine. *Id*. The record does not contain information about who supervised Mr. R. However, the situs/function tests focus on the work and where it was done, rather than who supervised whom, so I do not find this to be a reason to deviate from the finding in *Mitchell*. Applying *Mitchell*, Mr. R.'s employment as a coal car cleaner satisfies both the situs and function elements because Mr. R. worked at the mine preparing coal for delivery. Accordingly, Mr. R. was a miner when he cleaned out coal cars at the mine while working for the railroad.

[5]Although I am bound by the appellate court's decision, I note that the coal dust Mr. R. was exposed to during his coal car cleaning came from residual, processed coal that remained in the hopper car after the delivery of the full load to a commercial customer. In other words, Mr. R.'s work could just as likely be viewed as the final phase of the delivery of processed coal. Since Mr. R. was cleaning coal cars after the delivery of processed coal, he may not be the type of transportation worker Congress envisioned in the Act, such as a worker who transports raw coal from the mine to tipple.

Next, I will evaluate Mr. R.'s employment as a trackman to see if it qualifies him as a miner. Although he was occasionally exposed to coal dust from passing railroad cars as he worked on the railroad tracks, he did not work in or around a coal mine during this time. The railroads tracks described in Mr. R.'s testimony were used for the delivery of coal to consumers, not the extraction or preparation of coal, so Mr. R.'s work as a trackman fails the situs test. If employment fails the situs test, it does not qualify as mining work, so in this claim Mr. R.'s work as a trackman does not qualify his as a miner.

In summary, Mr. R. was a miner when he worked as a coal car cleaner, and he was not a miner when he was a trackman.

Issue # 2 – Length of Coal Mine Employment

Having determined that Mr. R. was a coal miner when he cleaned coal cars, I turn to calculation of the specific periods of employment as a "coal miner" based on the following principles. According to 20 C.F.R. § 718.301, the length of coal mine employment is calculated in accordance with 20 C.F.R. § 725.101(a)(32). Section 725.101(a)(32) defines a year of coal mine employment as a calendar year of 365 or 366 days, or partial periods equal to one year, during which a miner worked in or around coal mines for at least 125 working (i.e., paid) days. If a miner worked at least 125 days in a calendar year or "partial periods totaling one year," then he is given credit for one year of coal mine employment. The term "working day" is defined as "any day . . . for which a miner received pay for work as a miner, but shall not include any day for which the miner received pay while on approved absence, such as vacation or sick leave." Thus, while sick and vacation leave days may be counted as part of the calendar year for the purposes of showing the duration of an employment relationship, they do not qualify as part of the requisite 125 "working" days.

The regulation sets out two ways to determine the length of coal mine employment. First, if the beginning and ending dates of coal mine employment can be ascertained and that time period spans a calendar year, then the miner receives credit for one year of coal mine employment. In that case, the regulation presumes the miner worked at least 125 days during that calendar year. 20 C.F.R. § 725.101(a)(32)(ii). Any credible evidence may be used to establish dates of employment, including, but not limited to, company records, co-worker affidavits, and sworn testimony. *Id*.

Second, if the evidence is insufficient to determine the beginning and ending dates of employment, or the employment covered less than a calendar year, 20 C.F.R. § 725.101(a)(32)(iii) sets out a somewhat complicated process to determine the length of coal mine employment using the miner's annual income and the coal mine industry's average daily earnings for that year, as reported by the Bureau of Labor Statistics.

The record contains sufficient evidence of the beginning and end dates of Mr. R.'s work as a coal car cleaner, so I will use the first method to determine Mr. R.'s length of coal mine employment. In his first claim for federal black lung disability benefits, Mr. R. wrote that he was employed from September 1957 until August 1966 by the Gulf Mobile Ohio Railroad at the "Southwestern" mine, and from August 1966 to January 1982 as a trackman for Illinois Central

Gulf Railroad. (DX 1) In his second application for black lung benefits, Mr. R. claimed 9 years as a coal miner. (DX 3) At the hearing, Mr. R. testified that he worked as a coal car cleaner from September 1957 until 1966. (TR, p.16,18) The record also contains a letter dated September 3, 1985, from Ken Wilson, Agent for Illinois Central Gulf Railroad Co., stating that Mr. R. was employed as a coal hopper car cleaner for the Old Gulf Mobile & Ohio Railroad Co. from September 1957 until August 1966. (DX 1, DX 5, and DX 20) Based on Mr. R.'s consistent employment data on his applications, his credible hearing testimony and corroboration from his employer's agent, and in the absence of any evidence to the contrary, I find that while cleaning coal cars prior to loading, Mr. R. was a coal miner from September 1957 to August 1966. Accordingly, Mr. R. had 9 years of coal mine employment.

Issue # 3 – Change in Applicable Condition of Entitlement

After the expiration of one year from the denial of benefits, the submission of additional material or another claim is considered a subsequent claim and adjudicated under the provisions of 20 C.F.R. § 725.309(d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of entitlement") has changed and is now present. 20 C.F.R. § 725.309(d)(3). If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309(d)(4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Co. v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

To receive black lung disability benefits under the Act, a claimant must prove four basic conditions, or elements, related to his physical condition. First, the miner must establish the presence of pneumoconiosis.[6] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[7] Third, the miner has to demonstrate he is totally disabled.[8] And fourth, the miner must prove the total disability is due to pneumoconiosis.[9]

[6]20 C.F.R. § 718.202.

[7]20 C.F.R. § 718.203(a).

[8]20 C.F.R. § 718.204(b).

[9]20 C.F.R. § 718.204(a).

Based on those four essential conditions of entitlement, the adjudication of a subsequent claim involves the identification of the condition(s) of entitlement a claimant failed to prove in the prior claim and then an evaluation of whether through newly developed evidence a claimant is able to now prove that condition(s) of entitlement. Mr. R.'s prior claim was denied in October 1985 due to his failure to establish the presence of pneumoconiosis. Consequently, for purposes of adjudicating this subsequent claim, I will evaluate the evidence developed since the denial of the first claim to determine whether Mr. R. developed pneumoconiosis.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[10] The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis,[11] and legal pneumoconiosis, defined as "any chronic lung disease . . . arising out of coal mine employment."[12] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[13] As several courts have noted, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202(a)(1)), autopsy or biopsy report (§ 718.202(a)(2)), regulatory presumption (§ 718.202(a)(3)),[14] and medical opinion (§ 718.202(a)(4)). Because the record does not contain any evidence that the claimant had complicated pneumoconiosis and Mr. R. filed this claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. As a result, the presence of pneumoconiosis will have to be established by chest x-rays, autopsy reports, or medical opinion.

[10]20 C.F.R. § 718.201(a).

[11]Mrs. R. submitted two pages from a medical dictionary, CX 4, with two definitions highlighted. First, "anthracosis," is defined as "[b]lack pigmentation of lungs due to inhalation of carbon particles; causes chronic inflammation. A form of pneumoconiosis." Second, "pneumoconiosis," is defined as "[d]ust disease. Fibrosis of the lung caused by long continued inhalation of dust in industrial occupations. . . . Examples are silicosis, coal workers' p. or black lung disease . . . ."

[12]20 C.F.R. §§ 718.201(a)(1) and (2) (emphasis added).

[13]20 C.F.R. § 718.201(b).

[14]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202(a)(3), a coal miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the coal miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the coal miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
Nov. 18, 2003[15]	DX 14	Dr. Burr, BCR[16]	Negative for pneumoconiosis. Probable lung hyperinflation. Mild aortic atherosclerosis.
Nov. 10, 2005	CX 1	Dr. Istanbouli	(Negative for pneumoconiosis.)[17] Mild vascular congestion with underlying minimal granulomatous changes, otherwise no acute lung disease
Nov. 14, 2005 (portable chest x-ray)	CX 1	Dr. Ailinani	(Negative for pneumoconiosis. No significant interval change since 11/13/05 x-ray. Cardiomegaly with minimal vascular congestion and bilateral minimal pleural effusions, unchanged.

None of the three physicians reviewing the recent chest x-rays in this claim found the presence of pneumoconiosis. Consequently, the preponderance of the chest x-ray evidence is negative and the presence of pneumoconiosis cannot be established through radiographic evidence under 20 C.F.R. § 718.202(a)(1).

Autopsy Evidence

(Note: the following summary of the autopsy findings, and other portions of this decision, contain detailed information concerning Mr. R.'s death submitted to support his living miner claim. While respecting the dignity and privacy of the deceased, some discussion of the detailed observations is nonetheless necessary because I find the medical information relevant to determine whether Mr. R. had pneumoconiosis.)

Prior to summarizing the autopsy report, a review of the regulatory provisions on the requisite standard for diagnosing pneumoconiosis based on a biopsy or autopsy is helpful. The regulation at 20 C.F.R. § 718.201(a)(1) defines "clinical" pneumoconiosis as a condition:

> characterized by permanent deposition of substantial amounts of particulate matter, caused by coal dust exposure, in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis,

[15]Dr. Burr incorrectly listed Mr. R.'s birthday as the date of the chest x-ray.

[16]The following designations apply: B – B reader and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

[17]Since a physician evaluating a chest x-ray can be expected to accurately report the presence of any abnormalities, an administrative law judge may infer that the absence of a mention of pneumoconiosis indicates pneumoconiosis was not present. *See Marra v. Consolidation Coal Co.* 7 B.L.R. 1-216, 1-219 (1985).

anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, and silicotuberculosis arising out of coal mine employment.

Consequently, because the regulatory definition of clinical pneumoconiosis requires both a deposit of coal dust matter and lung tissue reaction to the deposit, an autopsy finding of anthracotic pigmentation, standing alone, is not sufficient to establish the presence of pneumoconiosis, 20 C.F.R. § 718.202(a)(2).

Dr. John A. Heidingsfelder
(CX 3)

On November 20, 2005, Dr. Heidingsfelder, board certified in anatomic, clinical, and forensic pathology, conducted a chest-only autopsy of Mr. R. Upon initial examination, the anterior chest region revealed pink to bluish-gray discolored pleural surfaces. The lungs revealed marked anthracotic pigment deposition bilaterally. Focal pleural fibrous adhesions of both lungs to lateral chest wall, and additional adhesions between the individual lobes of the lung. Clear, watery, bilateral pleural effusions. The inner chest walls showed focal regions of pink-white fibrous plaque formation on the parietal pleural surface of the right and left lateral chest wall regions. The plaques measured 1.5 cm and 2 cm at their greatest dimension. The undersurface of the anterior rib plate revealed a thin fibrous plaque overlying the undersurface of the sternum. The heart was moderately enlarged, especially in the left ventricle.

Upon gross examination, the heart displayed abundant bright yellow adipose tissue. The left anterior descending coronary artery revealed focal moderate calcification and focal moderate atherosclerotic narrowing with 50-60% blockage due to the calcific atherosclerotic plaque. The left circumflex and right coronary arteries showed mild atherosclerotic changes. The left ventricle was moderately hypertrophic, with an average thickness of 2.0 cm to 2.2 cm. The right ventricle was 0.2 cm to 0.4 cm thick.

Upon gross examination, the pleural surface of the lungs showed a pattern of "marked" anthracotic pigment deposition, which is more intense in the upper lobe than the lower lobe. The pulmonary artery and veins did not show evidence of thromboemboelic phenomenon. The bronchial mucosa of the right and left main stem bronchus showed mild trenching and pitting. The lung tissue revealed a pattern of moderate anthracotic pigment deposition. The lung tissue also showed marked parenchymal emphysematous changes, evidenced by moderately dilated air spaces, from 0.2 cm to 1 cm wide, in the tissue. No frank emphysematous blebs or bullous emphysematous changes were seen. The lower lobes showed a pattern of moderate pulmonary edema and congestion, with somewhat lesser degrees of emphysematous changes. The peritracheal and hilar nodes revealed moderate grayish-black anthracotic pigment within lymph nodal regions. Sections of the lung also showed focal regions of mild interstitial fibrosis. There was no evidence of purulent changes, abscess formation, consolidation, cysts, tumors, or masses in the lung tissue.

Although Dr. Heidingsfelder retained tissue samples of the heart and lung, the autopsy report does not contain a description of microscopic findings.

Based on his evaluation, Dr. Heidingsfelder diagnosed 1) focal pleural fibrous adhesions, 2) parietal pleural fibrous plaques of right and left lateral chest wall and substernal regions, 3) marked pulmonary anthracosis, 4) moderate to marked pulmonary emphysema, 5) focal interstitial pulmonary fibrosis changes, 6) bilateral pleural effusions, 7) cardiomegaly with moderate left ventricle hypertrophy, and 8) moderate atherosclerosis with calcification of left anterior descending coronary artery with focal 50-60% narrowing due to calcific atheromatous plaque.

Dr. Samuel V. Spagnolo
(DX 25)

On March 18, 2006, Dr. Spagnolo, board certified in internal medicine and pulmonary disease,[18] reviewed Dr. Heidingsfelder's report from Mr. R.'s autopsy. Dr. Spagnolo noted that the autopsy report indicated the presence of focal pleural adhesions, pleural plaques, cardiac disease, and emphysema. The report also indicated the presence of "moderate anthracotic pigment" in the lung tissue, but this finding could occur from smoking cigarettes, urban living, and coal dust exposure, and is not sufficient to diagnose pneumoconiosis.

Discussion

Based on his autopsy, Dr. Heidingsfelder diagnosed pulmonary anthracosis, a recognized form of pneumoconiosis in 20 C.F.R. § 718.201(a)(1). After reviewing Dr. Heidingsfelder's autopsy report, Dr. Spagnolo concluded Mr. R. did not have pneumoconiosis. In resolving this medical dispute, I give Dr. Heidingsfelder's conclusion greater probative value based on two significant findings in the autopsy report related to the presence of pneumoconiosis. First, upon both gross examination and sectioning of the lungs, Dr. Heidingsfelder reported a significant pattern of anthracotic pigment deposition. Second, and significantly, Dr. Heidingsfelder also noted focal areas of interstitial fibrosis. The combination of both findings support Dr. Heidingsfelder's diagnosis of anthracosis.

Dr. Spagnolo's opinion suffers a loss of probative value because he focused solely on the first finding of anthracotic pigmentation. While Dr. Spagnolo correctly observed the presence of anthracotic pigment is insufficient to support a diagnosis of pneumoconiosis, the physician did not address the additional finding of interstitial fibrosis.

Accordingly, based on Dr. Heidingsfelder's probative diagnosis, I find the presence of pneumoconiosis is proven through probative autopsy evidence under 20 C.F.R. § 718.202(a)(2).

Correspondingly, through proof of the presence of pneumoconiosis, a material change in conditions has been demonstrated, establishing an element of entitlement previously adjudicated against Mr. R. in his most recent prior claim. As a result, under 20 C.F.R. § 725.309(d), denial of Mr. R.'s present claim is no longer appropriate. Instead, I will review the entire record to determine whether Mrs. R. can prove all four elements necessary for Mr. R.'s entitlement of black lung disability benefits under the Act; thereby establishing that he was totally disabled due to coal workers' pneumoconiosis. During this process, according to 20 C.F.R. § 725.309(d)(4),

[18]I take judicial notice of Dr. Spagnolo's board certification and have attached the certification documentation.

"no finding made in connection with the prior claim . . . shall be binding on any party in the adjudication of the subsequent claim."

Issue # 4 – Entitlement to Benefits

As previously discussed, to establish entitlement to black lung disability benefits under Act, a claimant must prove: a) the presence of pneumoconiosis; b) pneumoconiosis related to coal mine employment; c) total pulmonary disability; and, d) total disability due to coal workers' pneumoconiosis.

Pneumoconiosis

Chest X-Rays

In addition to the radiographic evidence discussed above, Mr. R.'s first claim contained the following chest x-rays.

Aug. 16, 1985	DX 1	Dr. Burr, BCR	Negative for pneumoconiosis. Mild aortic atherosclerosis.
(same)	DX 1	Dr. Pitman, BCR, B	Completely negative.

Once again, consideration of the older chest x-rays does not alter the prior determination that the radiographic evidence does not show the presence of pneumoconiosis under 20 C.F.R. § 718.202(a)(1).

Autopsy Evidence

As discussed above, the preponderance of the autopsy/pathology evidence demonstrates the presence of pneumoconiosis in Mr. R.'s lungs. Clearly, nothing in the earlier first claim alters that determination. Accordingly, for the reasons discussed above, Mrs. R. has proven the existence of pneumoconiosis in her husband's lungs under 20 C.F.R. § 718.202(a)(2).

Pneumoconiosis Arising Out of Coal Mine Employment

Having proven the presence of pneumoconiosis, Mrs. R. must next establish that Mr. R.'s pneumoconiosis arose, at least in part, out of coal mine employment. According to 20 C.F.R. § 718.203(b), if a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment. In this claim I found 9 years of coal mine employment. As a result, Mr. R. is not entitled to the regulatory presumption.

If a miner suffers from pneumoconiosis and was employed for less than ten years in the coal mines, it shall be determined that such pneumoconiosis arose out of that employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c); *see also Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986). Specifically, the claimant has met his burden of proof under § 718.203(c) when "competent evidence establish[es] that his pneumoconiosis is

significantly related to or substantially aggravated by the dust exposure of his coal mine employment." *Shoup v. Director, OWCP*, 11 B.L.R. 1-110, 1-112 (1987).

In *Barnes v. Director, OWCP*, 19 B.L.R. 1-71 (1995) (en banc on reconsideration), the BRB stated that an ALJ should "consider whether the record contains any documentary or testimonial evidence to suggest that any causal factors other than coal dust exposure as a cause of claimant's pneumoconiosis." An ALJ should look to the medical evidence for the relationship between pneumoconiosis and coal mine employment, and should not "infer a relationship based merely upon claimant's employment history." *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1986).

In assessing whether Mr. R.'s pneumoconiosis was due to his coal mine employment, several factors need to be considered. First, the presence of pneumoconiosis has been established through autopsy evidence of anthracotic pigment and interstitial fibrosis. Second, according to Dr. Spagnolo, anthracotic pigment may be attributable to coal mine dust, urban living, and cigarette smoke. Third, Mr. R. faced three significant pulmonary risks during his lifetime: at least a 40 pack year[19] history of cigarette smoking, 9 years of coal dust exposure during coal car cleaning work, and coal dust exposure for 16 years as a trackman.

Upon consideration of these three factors, I first recognize that a combination of two, or all three of the factors together, including Mr. R.'s dust exposure as a coal miner could have caused the anthracotic deposit in Mr. R.'s lungs. However, the exposure associated with each pulmonary health hazard standing alone may also have been sufficient to produce the anthracotic pigmentation. Due to the latter possibility and in the absence of any definitive evidence or medical opinion on the cause of Mr. R.'s anthracotic pigmentation, I find Mrs. R. is unable to meet the burden of proof on this element of entitlement. Accordingly, Mrs. R. has failed to establish that Mr. R.'s pneumoconiosis is related to his 9 years as a coal car cleaner under 20 C.F.R. § 718.203(c).[20]

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204(b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204(b)(1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary

[19]A pack year equals the consumption of a pack of cigarettes a day for one year.

[20]In his August 1985 pulmonary evaluation of Mr. R., Dr. Singh opined that Mr. R.'s chronic obstructive pulmonary disease was due in part to his coal mine employment. His diagnosis represents legal pneumoconiosis, which by definition attributes the pneumoconiosis due to coal mine dust exposure. However, Dr. Singh's opinion has little probative weight because he simply rendered the conclusion without identifying the portions of his pulmonary examination that supported his conclusion.

condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, that to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

The record does not contain sufficient evidence that Mr. R. has complicated pneumoconiosis and nor is there evidence of cor pulmonale with right-sided congestive heart failure. As a result, total respiratory or pulmonary disability must be demonstrated through pulmonary function tests, arterial blood-gas tests, or medical opinion.

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV_1 pre[21] post[22]**	**FVC pre post**	**MVV pre post**	**% FEV_1 / FVC pre post**	**Qualified[23] pre post**
DX 1	Aug. 16, 1985 Dr. Singh	64 67”	1.17 --	1.63 --	34.8 --	71.8%	Yes[24]
DX 1	Nov. 24, 2003 Dr. Pineda	82 65”	1.02 1.19	2.45 2.67	42 45	41.6% 44.6%	Yes[25] Yes

Under the provisions of 20 C.F.R. § 718.204(b)(2)(i), if the preponderance of pulmonary function tests qualify under Appendix B of Section 718, then in the absence of evidence to the contrary, the pulmonary tests shall establish a miner’s total disability. This regulatory scheme requires a five step process.

First, an administrative law judge must determine whether the tests conform to the procedural requirements in 20 C.F.R. § 718.103. Second, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. *See Vivian v. Director, OWCP [Alley]*, 897 F.2d 1045 (10th Cir. 1990). Concerning validity, more weight may be given to the observations of technicians who administered the tests than the doctor who

[21]Test result before administration of a bronchodilator.

[22]Test result after administration of a bronchodilator.

[23]Under 20 C.F.R. § 718.204(b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner’s age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718 (2001), and either the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal or less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[24]The qualifying value for FEV1 is 1.75 or less, for FVC it is 2.24 or less, and for MVV it is 70 or less.

[25]The qualifying value for FEV1 is 1.48 or less, for FVC it is 1.92 or less, and for MVV it is 59 or less.

reviewed the tracings. *Revnack v. Director, OWCP*, 7 B.L.R. 1-771 (1985). As a result, if an administrative law judge credits the reviewing doctor's opinion over the technician who actually observed the test, he must provide a rationale. *Brinkley v. Peabody Co*., 14 B.L.R. 1-147 (1990). Third, the test results are compared to the qualifying numbers listed in Appendix B to determine whether the tests show total disability. Fourth, a determination must be made whether the preponderance of the conforming and valid pulmonary function tests supports a finding of total disability under the regulation. In that regard, more probative weight may be given to the results of a more recent study over those of an earlier test. *Coleman v. Ramey Coal Co*., 18 B.L.R. 1-9 (1993). Fifth, if the preponderance of conforming tests establishes total disability under the regulation, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, it must be given appropriate evidentiary weight and compared against the pulmonary function test evidence that supports a finding of total respiratory disability. *Fields v. Island Creek Coal Co*., 10 B.L.R. 1-19, 1-21 (1987).

In Mr. R.'s case, the pulmonary function tests appear to be conforming and the preponderance of the physicians determined the tests were valid.[26] Both pulmonary function tests produced results that met the regulatory standard for total disability. Consequently, Mr. R. may be able to establish total disability through preponderance of the conforming, valid, and qualifying pulmonary function tests, absent evidence to the contrary.

Other Medical Evidence

The recent chest x-rays, standing alone, do not provide contrary evidence. Similarly, although the arterial blood gas studies did not reach total disability threshold, those tests measure different aspects of respiratory function and do not contradict a finding of total disability due to a pulmonary obstruction established by pulmonary function tests. Finally, at least two of the three physicians to consider Mr. R.'s pulmonary capacity to return to coal mining, Dr. Pineda and Dr. Spagnolo, DX 9 and DX 25, determined that he was totally disabled. Consequently, the medical opinion is consistent with, rather than contrary to, the preponderance of the most recent pulmonary function tests showing total disability.

Conclusion

Accordingly, based on the preponderance of the most recent pulmonary function tests, and in the absence of contemporaneous contrary evidence, I find that Mr. R. is totally disabled pursuant to the provisions of 20 C.F.R. § 718.204(b)(2)(i).

Total Disability Due to Coal Workers' Pneumoconiosis.

Proof that a claimant has a totally disabling pulmonary disease does not by itself establish the impairment is due to pneumoconiosis. Pursuant to 20 C.F.R. § 718.204(c)(1), absent a

[26]Although Dr. Spagnolo questioned the validity of one of the two studies, he found the November 24, 2003 test to be valid (DX 25). Additionally, Dr. Long and Dr. Gerblich specifically determined the August 16, 1985 and November 24, 2003 pulmonary function tests were valid (DX 1 and DX 12).

favorable regulatory presumption,[27] a claimant must demonstrate that pneumoconiosis was a substantially contributing cause of the total disability by showing the disease: 1) had a material, adverse effect on his respiratory or pulmonary condition; or, 2) materially worsened a totally disabling respiratory impairment caused by a disease or exposure unrelated to pneumoconiosis. Additionally, 20 C.F.R. § 718.204(c)(2) mandates that "the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report."

To address this issue, a review of the remaining medical evidence in this claim is warranted.

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO^2 (rest) pCO^2 (exercise)**	**pO^2 (rest) pO^2 (exercise)**	**Qualified**
DX 1	Aug. 21, 1985 Dr. Singh	41.6 --	70.2 --	No[28]
DX 10	Dec. 27, 2002 Dr. Forehand	39 35	68 63	No[29] Yes[30]
DX 1	Nov. 24, 2003[31] Dr. Pineda	37 --	71 --	No[32]
CX 1	Nov. 6, 2005[33] Dr. Kupferer	105.6 --	113 --	Yes[34]
CX 1	Nov. 2005[35] Dr. Kupferer	45 --	67 --	No On ventilator
CX 1	Nov. 2005[36] Dr. Kupferer	61.7 --	63 --	Yes

[27]20 C.F.R. § 718.305 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption the claimant is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more of coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and, 20 C.F.R. § 718.306 (a presumption exists when a survivor files a claim prior to June 30, 1982).

[28]For a pCO^2 of 40-49, the qualifying pO^2 is 60 or less.

[29]For a pCO^2 of 39, the qualifying pO^2 is 61 or less.

[30]For a pCO^2 of 35, the qualifying pO^2 is 65 or less.

[31]Mr. R. stated that he was on oxygen as the time of this test. TR., p.45.

[32]For a pCO^2 of 37, the qualifying pO^2 is 63 or less.

[33]The arterial blood gas studies done by Dr. Kupferer and Dr. Cowart were done in the course of Mr. R.'s treatment and hospitalization.

[34]For a pCO^2 over 50, any pO^2 value qualifies.

[35]The date was between November 6 and 8, 2005.

[36] The date was between November 7 and 8, 2005.

CX 1	Nov. 8, 2005 Dr. Cowart	42.4 --	96 --	No On ventilator
CX 1	Nov. 9, 2005 Dr. Cowart	47.0 --	82 --	No
CX 1	Nov. 10, 2005 Dr. Cowart	51.9 --	79 --	Yes
CX 1	Nov. 10, 2005 Dr. Cowart	52.9 --	76 --	Yes
CX 1	Nov. 10, 2005 Dr. Cowart	66.9 --	74 --	Yes
CX 1	Nov. 11, 2005 Dr. Cowart	73.8 --	84 --	Yes
CX 1	Nov. 11, 2005 Dr. Cowart	82.3 --	83 --	Yes
CX 1	Nov. 12, 2005 Dr. Cowart	62.3 --	91 --	Yes
CX 1	Nov. 12, 2005 Dr. Cowart	71.1 --	88 --	Yes
CX 1	Nov. 12, 2005 Dr. Cowart	56.7 --	76 --	Yes
CX 1	Nov. 12, 2005 Dr. Cowart	74.7 --	58 --	Yes
CX 1	Nov. 13, 2005 Dr. Cowart	68.6 --	272[37] --	Yes
CX 1	Nov. 14, 2005 Dr. Cowart	77.0 --	59 --	Yes
CX 1	Nov. 14, 2005 Dr. Cowart	60.9 --	69 --	Yes
CX 1	Nov. 14, 2005 Dr. Cowart	62.8 --	70 --	Yes
CX 1	Nov. 15, 2005 Dr. Cowart	48.7 --	73 --	No
CX 1	Nov. 15, 2005 Dr. Cowart	40.2 --	84 --	No

Dr. Arjinderpal Singh
(DX 1)

Dr. Singh evaluated Mr. R.'s pulmonary health on August 21, 1985. Mr. R. had high blood pressure, smoked 2 packs of cigarettes a day for 50 years until October 1984, and complained of coughing, wheezing, dyspnea, and chest pain. The chest x-ray was negative for pneumoconiosis. Dr. Singh diagnosed chronic obstructive pulmonary disease ("COPD") due to smoking and coal mine dust exposure.

Dr. Raymund Pineda
(DX 9)

On November 18, 2003, Dr. Pineda evaluated Mr. R.'s pulmonary health. Mr. R. complained of chronic productive cough with intermittent wheezing and shortness of breath. Mr. R. was "02 dependent" since May 25, 2003. Mr. R. had a history of pneumonia and high blood

[37]This appears to be a typo on the report.

pressure, and he smoked 2 to 3 packs per day from 1942 to 1982. Mr. R. hauled coal for a coal company from 1957 to 1966, and did track work for a railroad from 1966 to 1982.

Upon physical exam, Dr. Pineda noted that Mr. R. could communicate in long phrases before stopping to catch his breath. Mr. R.'s lungs revealed distant lung sounds, with no evidence of wheezing, and a slightly prolonged expiratory phase. Mr. R.'s heart had a normal rate and rhythm, with no gallops or murmurs. The chest x-ray only showed cardiomegaly and atheromatous aorta. The spirometry indicated a moderate obstruction with significant improvement with bronchodilators. The electrocardiogram ("EKG") was normal. The blood gas study showed moderate hypoxemia on room air.

Based on his examination, Dr. Pineda diagnosed hypertension and a moderate lung impairment, most likely secondary to COPD and cigarette smoking. Dr. Pineda noted that his COPD diagnosis was based Mr. R.'s spirometry which revealed a moderate obstruction that improved significantly with bronchodilators. Based on his respiratory impairment, Mr. R. was unable to perform his work as a coal miner. Additionally, further exposure to toxic fumes, gases, and dust would be detrimental to Mr. R.'s lungs.

Dr. Thomas Kupferer, Dr. Randy Cowart, and Dr. Scott Williams
(CX 1 and CX 2)

On May 6, 2003, Dr. Kupferer admitted Mr. R. to the hospital. Although Mr. R. was initially treated for COPD, Dr. Kupferer believed interstitial pulmonary fibrosis should be considered instead. Dr. Cowart also evaluated Mr. R., diagnosed progressive kidney failure, and noted high blood pressure. Mr. R. was discharged on May 13, 2003.

On November 6, 2005, Mr. R. was admitted to the St. Joseph Memorial Hospital emergency room for shortness of breath and weakness. His initial blood gas study was pCO2 105.6, pO2 113. He was referred to the intensive care unit. Dr. Kupferer noted that his CO2 mildly decreased in the third blood gas test following his admission, but an hour later he began to retain more CO2, so he was placed on a ventilator. Mr. R. began to display hypertension, which was treated and his blood pressure returned to acceptable levels. On the ventilator, Mr. R.'s blood gases "improved dramatically," to a normal pH, pO2 67, pCO2 45. Mr. R. was treated with antibiotics. On November 7, 2005 Mr. R.'s blood pressure was "quite high," which was treated with medication. An attempt at removing the ventilator led to increased CO2, so Mr. R. was put back on the ventilator. The EKG showed a normal sinus rhythm, with nonspecific ST T-wave abnormalities. "Imaging studies in addition CT scan of the chest showed mild pulmonary vascular congestion and [mild] right pleural effusion." The chest CT scan on November 7 showed a focal opacity in the right medial upper lobe, possibly representing atelectasis. There was evidence of coronary disease and calcification in the pulmonary vasculature. A CT scan of the abdomen showed mild small right pleural effusion, cholelithiasis, and right renal cyst.[38] The most recent blood gas study was pO2 63, pCO2 61.7. Mr. R. was transferred to the Memorial Hospital of Carbondale for dialysis and continued use of the ventilator.

[38]The CT scan report is not in the record.

Mr. R. arrived at the Memorial Hospital of Carbondale on November 8, 2005, on a ventilator and diagnosed with acute renal failure and a history of black lung, COPD, hypertension, and congestive heart failure. Upon physical exam on November 9, 2005, Dr. Scott Williams heard no rales, rhonchi, or wheezes. A November 9, 2005 echocardiogram showed moderate pulmonary hypertension. On November 10, 2005, Dr. Suhail Istanbouly heard reduced air bilaterally, but no wheezes or rales. A chest x-ray revealed "mild vascular congestion with underlying minimal granulomatous changes, otherwise no acute lung disease." On November 13, 2005, Mr. R.'s chest x-ray showed bilateral pleural effusions and basilar air space disease, possible edema or pneumonia. Bronchodilator and bronchial hygiene therapy were indicated. On November 14, 2005 a therapist heard rhonchi in apices, a congested spontaneous weak cough. Later that day, Mr. R. was placed back on a ventilator following surgery. On November 16, 2005, Mr. R. was transferred to St. Joseph Memorial Hospital. Mr. R. was on oxygen until his death on November 18, 2005.

Following an autopsy, Dr. Kupferer signed Mr. R.'s death certificate (CX 2), noting pulmonary emphysema as the immediate cause of death, as a consequence of end-stage chronic kidney disease with pulmonary anthracosis as a significant contributing condition.

Dr. Samuel V. Spagnolo
(DX 25)

On March 18, 2006, Dr. Spagnolo evaluated Mr. R.'s medical record, including DOL examinations, medical treatment records, the autopsy report, and the death certificate. Mr. R. was exposed to coal dust for nine years working for the railroad, and he smoked between one and two packs of cigarettes per day for 40 years. Mr. R. was chronically hypertensive and suffered from severe renal disease and cardiac disease with evidence of ischemic cardiomyopathy. The physical findings suggested moderate airway obstruction with normal blood oxygen values, and the chest x-rays demonstrated heart disease, but did not present evidence of pneumoconiosis.

Dr. Spagnolo indicated that breathing difficultly can be the result of cardiac disease. Exercise intolerance manifested as exertional dyspnea and fatigue is "frequently the primary symptom of congestive heart failure." Additionally, morning wheezing, night-time cough, and decreased blood oxygen levels can indicate heart failure. Mr. R. had clinical and pathologic features of "diminished (failing) heart function." Dr. Spagnolo attributed Mr. R.'s medical condition prior to his death to 1) his smoking history, which resulted in emphysema with moderate airflow obstruction; 2) the effects of chronic hypertension and atherosclerotic cardiovascular disease, which led to coronary insufficiency and cardiac failure; and 3) severely reduced kidney function.

Although Mr. R. had a reduced capacity to perform his prior work, it was not caused in whole or in part by pneumoconiosis. Even if Mr. R. was found to have coal workers' pneumoconiosis, Dr. Spagnolo stated that his opinion "regarding the degree and cause of any respiratory disability would not change."

Discussion

In their treatment notes, Dr. Kupferer, Dr. Cowart, and Dr. Williams did not render an opinion on the cause of Mr. R.'s pulmonary impairment. Similarly, although the August 1985 pulmonary function test showed a pulmonary obstruction, Dr. Singh did not address the cause of the impairment. Of the numerous physicians who evaluated and treated Mr. R., only Dr Pineda and Dr. Spagnolo specifically addressed the cause of his pulmonary impairment. Dr. Pineda attributed Mr. R.'s COPD to his hypertensive coronary vascular disease. Dr. Spagnolo essentially reached the same conclusion and specifically concluded that Mr. R. was not totally disabled due to coal workers' pneumoconiosis. Accordingly, since no medical opinion in the record links Mr. R.'s pulmonary impairment to his pneumoconiosis, Mrs. R. is unable to prove the Mr. R. was totally disabled due to coal workers' pneumoconiosis under 20 C.F.R. § 718.204(c)(1).

CONCLUSION

The nine years Mr. R. spent working for the railroad company cleaning coal cars qualified him as a "coal miner" under the Act. Although the chest x-rays in the record did not show the presence of pneumoconiosis, the autopsy established that Mr. R. had anthracotic pigment deposits and fibrotic reaction in his lungs when he passed away, establishing the presence of pneumoconiosis under 20 C.F.R. § 718.202(a)(2). Likewise, the preponderance of the pulmonary function tests demonstrate that Mr. R. had a totally disabling pulmonary impairment. However, in the absence of the 20 C.F.R. § 718.203(b) causation presumption, and considering Mr. R. faced three distinct and significant pulmonary risks that could produce anthracotic pigmentation, Mrs. R. is unable to prove that his pneumoconiosis arose out of his employment as a coal miner for nine years. Further, in the absence of any probative medical opinion, Mrs. R. is unable to prove that her husband's pulmonary impairment was due to pneumoconiosis. Accordingly, since Mrs. R. has failed to prove the second and fourth elements of entitlement, Mr. R.'s claim for black lung disability benefits must be denied.

ORDER

Accordingly, the black lung disability claim of MR. H.R. is **DENIED**.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: December 22, 2006
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Attachment No. 1

American Board of Medical Specialties
Certification:

Samuel Vincent Spagnolo, MD

Certified by the American Board of Internal Medicine in:

Internal Medicine
Pulmonary Disease

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